STUDENT APPLICATION INFORMATION

DIVISION OF SERVICES FOR THE BLIND AND VISUALLY IMPAIRED

Part I. General Information

Name:		**Preferred Name:**
Address:		
Gender Male ☐ Female ☐	**E-Mail Address:**	**Date:**
Home Phone Number:	**Cell Phone Number:**	
Type of Cell Phone (i.e. Apple iPhone 5C):		
Birth Date:	**Height:**	**Weight:** **Shoe Size:**

Emergency Contact Information

Name:	**Telephone Number:**	**Relationship:**

Do you live alone, with family or other?	**Alone** ☐	**Family** ☐	**Other** ☐

Open Rehabilitation Case? Yes ☐ No ☐	**Counselor Name:**

Level of education completed or college degrees earned:	**High School** ☐	**Some college** ☐	**Associate** ☐	**Bachelor** ☐	**Master** ☐	**Doctorate** ☐

Have you ever been convicted of a felony or misdemeanor? Yes ☐ No ☐

If yes, please explain:

Part II. Disability Information

The training program is a highly physical, mental and emotional learning experience. Please describe any additional disabilities or concerns. This will help us meet your individual needs. If yes, please provide an explaination.

Cause of vision loss: **Length of time from onset of vision loss:**

Stability of vision:	**Stable at least 2 years** ☐	**Changing rapidly** ☐	**Changing Slowly** ☐	**Permanent total blindness** ☐

Medical Conditions:	Yes ☐	No ☐	
Physical Limitations:	Yes ☐	No ☐	
Mental /Learning Limitations	Yes ☐	No ☐	
Allergies:	Yes ☐	No ☐	
Other Considerations:	Yes ☐	No ☐	

Part III Skills Assessment

Use the abbreviations below to assess your current skill level on the following tasks:
Y = Can Do T = Training Needed NA = Not Applicable O = Other D = Decline To Answer

	Understand eye condition, care and treatment.
	Demonstrate positive regard for disability including adaptation needs.
	Express emotions in an age appropriate manner.
	Manage personal hygiene-i.e. teeth, hair, bathing, nails.
	Dress self in appropriate attire for various social settings.
	Identify and match clothing appropriately-i.e. mark, organize and label.
	Operate washer and dryer, sort, fold and put away laundry.
	Complete simple household tasks (load dishwasher, take out trash, sweep, dust, vacuum, make bed).
	Use adaptive techniques to locate/serve food.
	Use utensils appropriately at table.
	Prepare simple meals (sandwich, soup, drink).
	Use safe techniques for range, oven, microwave.

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	Manage money, budget.
	Establish/maintain checking/savings account.
	Shop for groceries/items independently.
	Tell time.
	Maintain schedule/calendar.
	Move in familiar environment, recognize landmarks.
	Recognize directions, spatial awareness.
	Walk familiar neighborhood routes.
	Travel in public areas effectively.
	Use public transportation.
	Arrange own transportation/hire driver.
	Demonstrate basic social skills (face others to speak, please/thank you, take turns, and share).
	Initiate a conversation.
	Participate in group activities.
	Respond appropriately to peer pressure or difficult interactions.
	Know un-contracted Braille.
	Know contracted Braille. Reading WPM_____
	Use slate and stylus. Writing WPM_____
	Use a Perkins Braillewriter. WPM_____
	Operate electronic devices.
	Use adaptive technology such as cell phone, note taker, talking products.
	Use computer for home, recreational and classroom needs.
	Identify needed accommodations to complete tasks.
	Use telephone independently to access and disseminate information.
	Take and organize notes.
	Use a reader effectively.
	Understand educational rights/responsibilities.

Part III Medical Provider Information

Are you familiar with safety skills such as accessing emergency services, understanding and complying with emergency evacuation procedures, managing first aid care on self, etc.? Yes ☐ No ☐

Name(s) of Medical Practitioner:	Address:	Telephone Number:
Preferred Hospital Name:	**Address:**	**Telephone Number:**
Medical Insurance Provider(s):	**Membership Number(s):**	**Telephone Number:**

Can you manage your own health care and self-administer medications?	Yes ☐	No ☐

Current List of Medications:	Dosage:	Frequency:
Current List of Medications continued:	**Dosage:**	**Frequency:**

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Additional Questions:

What are your greatest strengths?
What are your greatest weaknesses?
What do you want to accomplish from this training experience?
What goals do you have for your future?
I understand this is a non-visual training program and I will be required to wear training shades in order to keep a full-time or part-time status. Please sign your name to indicate that you are willing to abide by this requirement. Electronic signature is accepted.
Student Signature: _____